MDR: M4-02-3816-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 07/20/01.
   b. The request was received on 05/31/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC-60 and Position Statement on TWCC-60
   b. HCFAs-1500
   c. EOB
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II: No Response

3. Based on Commission Rule 133.307 (g) (4), the Division notified the insurance carrier Austin Representative of their copy of the requestor's 14 day additional information on 07/15/02. The insurance carrier did not submit a response to the additional information. The "No Information Found In Case File" sheet is reflected in Exhibit II of the Commission's Case File.

4. Notice of A Letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: TWCC-60
   "Refusal of respondent in reimbursement of services for hearing aid expense due to their request of manufacturers invoice from provider. This request has never been required of us as a provider for twcc [sic] in 30 + years."

2. Respondent: No Response

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 07/20/01.

2. Per the provider's TWCC-60, the amount billed is $4,225.00; the amount paid is $271.00; the amount in dispute is $3,900.00.

3. The carrier denied the billed services by code, "CPT CODE V5050 IS NOT VALID. PLEASE RECODE AND RESUBMIT ONLY THAT CHARGE FOR FURTHER REVIEW. THANK YOU. $3900.00 [sic]"

4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
07/20/01	92590 V5050	$4,225.00	$271.00	CPT code not valid	$71.00	CPT descriptor; Rule 133.1 (a) (3) (C); Rule 133.304 (k) (1) (A); Rule133.307 (g) (3) (A), (B), (C)	The provider's initial request for medical dispute included a HCFA-1500 with V5050 RT-LT listed as the procedure code. The carrier EOB denied payment for the "V" code as not being a valid code. The provider submitted additional information for the medical dispute on 07/10/02. A new Table of Disputed Services with the CPT code 92590 substituted for V5050 code was included with the additional information. In the additional information packet, the provider submitted a Request for Reconsideration HCFA-1500 with the "V" code, but no Request for Reconsideration HCFA-1500 was submitted for the CPT code 92590. The provider failed to include any medical documentation to indicate that the service was rendered as billed. No additional reimbursement is recommended.
Totals		$4,225.00	$271.00				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 07th day of November 2002.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm